

PROVIDER CREDENTIALING APPLICATION



Please complete each section thoroughly by typing or clearly printing in blue or black ink.

Practitioner's Name	Date
Individual NPI	Tax ID

PLEASE INCLUDE THE FOLLOWING WITH THIS COMPLETED APPLICATION

- Copy of current DEA Registration (if applicable)
- Copy of current State Controlled Dangerous Substance (CDS) Certificate (if applicable)
- Copy of current professional liability insurance policy face sheet, showing expiration dates, limits, and practitioner's name
- Copy of Board Certification Certificate(s) (if applicable), or other National Certification Certificates **(if changed since date of last credentialing)**
- Copies of CME/CEU session certificates
- Signature requirements on pages 18 and 19
- Professional Peer References
- Copy of curriculum vitae
- W9

PROVIDER CREDENTIALING APPLICATION



1. Applicant Information				
Last Name (as shown on state license)	First Name	Middle Name	Maiden Name	Suffix (e.g., Jr., Sr., etc.)
Professional Designation (e.g., MD, DO, DDS, DPM, PA-C, RN, APN)	Gender	Birth Date	Birthplace	
	Male <input type="checkbox"/> Female <input type="checkbox"/>			
Other Name(s) Also Known By				
Name(s)	Name:		Name:	
Date Name Used	From:	To:	From:	To:
Area(s) of Specialty (please be specific and list any primary focus)				
Specialty:		Sub-specialty:		
Citizenship				
Are you a US Citizen?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Please provide the following information if you are not a US Citizen:	If no, what is your citizenship?			
	If no, what is status of your Visa?			
	If no, do you hold a permanent work permit?			
	Type of Visa:		Expiration of Visa:	
Social Security #	National Provider ID #	ECFMG # (if applicable, attach copy)	ECFMG Certificate Date	
Current Home Address		City	State	Zip Code
Home Telephone		Is this # unlisted?	Home Fax	
() -		<input type="checkbox"/> Yes <input type="checkbox"/> No	() -	
Language(s) Spoken (other than English)				

Misrepresentation of any statements and information provided by you in support of this application shall be considered fraudulent and may result in denial or revocation of appointment. (If more space is needed, please supply the information on a separate sheet and attach.)

2. Office Practice Information:						
If you have more than one office site or more than one billing address or entity, please make a photocopy of this section before completing it and provide information for each site or billing entity (i.e., multiple tax identifiers), as needed. Indicate below whether the office is the primary or an additional site. (NOTE: Only one primary site should be designated.)						
<input type="checkbox"/> Primary Office Site # 1			<input type="checkbox"/> Additional Office Site #			
Group/Practice Name						
Type of Practice		<input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Group <input type="checkbox"/> Corporation		<input type="checkbox"/> Hospital Based <input type="checkbox"/> Teaching or Research <input type="checkbox"/> Other (specify):		
Address (Building, Street, Suite #)			City			
State			Zip Code		County	
Telephone Number		Fax Number		Answering Service/After-Hours Number		
() -		() -		() -		
Alternate Telephone Number		Cell Phone Number		Beeper/Pager Number		
() -		() -		() -		
E-Mail Address				Long Range Beeper Number		
				() -		
Medicare Number		UPIN Number		Medicaid Number		
Are you currently accepting new patients?			Have you closed your practice to any plans or programs?			
<input type="checkbox"/> Yes <input type="checkbox"/> By referral only <input type="checkbox"/> No <input type="checkbox"/> NA			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA If Yes, please list:			
Handicap Accessible?			Public Transit Available?			
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA			
Does the office have other services available for disabled? (TTY, ASI, Mental/physical impairments, etc.)			If yes, list below what services are available			
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA						
Office Manager's Name		Nurse Manager's Name		Credentialing Contact		
<input type="checkbox"/> N/A		<input type="checkbox"/> N/A		Name <input type="checkbox"/> N/A Phone # Fax # E-mail		
Office Hours _____						
<input type="checkbox"/> Check if not applicable <input type="checkbox"/> Check if practitioner is not available to see patient during hours indicated						
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
AM	AM	AM	AM	AM	AM	AM
PM	PM	PM	PM	PM	PM	PM
Services Provided						
(Please check below if these services are available)						
<input type="checkbox"/> Lab Services		<input type="checkbox"/> On-Site		Reference Lab Name:		CLIA Number and Type of Certification:
<input type="checkbox"/> Radiology Services		<input type="checkbox"/> EKG		<input type="checkbox"/> Sigmoidoscopy		<input type="checkbox"/> Audiology Services <input type="checkbox"/> Treadmill
<input type="checkbox"/> Other (Please list):						

Misrepresentation of any statements and information provided by you in support of this application shall be considered fraudulent and may result in denial or revocation of appointment. (If more space is needed, please supply the information on a separate sheet and attach.)

<input type="checkbox"/> List any special diagnostic or treatment procedures performed in your office:			
Patient Population			
Do you limit the age of patients you treat?		If yes, what ages do you treat?	
<input type="checkbox"/> Yes <input type="checkbox"/> No		Minimum:	Maximum:
Remittance/Billing Information (NOTE: Must match information listed in box 33 on HCFA-1500)			
Are all services payable to one practice or group name/address?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Group/Practice Name (Check Payable To):			
Address (Building, Street, Suite #)		City	State
			Zip Code
Billing Office Telephone Number		Billing Manager's Name	
() - - - - - -			
Group NPI	Tax ID Number (must match W-9)	Name affiliated with Tax ID Number (must match W-9)	
Business Interests			
Do you or your business entity own, operate, have an interest in, or participate in any medical enterprise or business?		<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide details on separate sheet.	
Do you have a financial relationship with a hospital, clinical lab, nursing home, pharmacy, radiology lab, emergency room, or any other medical related organization?		<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide details on separate sheet.	
Practice Classification			
<input type="checkbox"/> Primary Care Physician (Family Practitioners, Internists, or Pediatricians who deliver primary health care services)			
<input type="checkbox"/> Specialist Physician (Physicians other than primary care physicians in their designated clinical practice)			
<input type="checkbox"/> Allied Health Professional (Licensed, certified, or registered non-physician practitioners of direct patient care services)			
<input type="checkbox"/> Dual Role (Serve as both a Primary Care Physician as well as a Specialist)			
Directory Listing			
Should this office be listed in the directory?		Should this office receive correspondence?	
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Please indicate, in preference order, how you wish to be listed in the directory.			
Primary Specialty:		Secondary Specialty:	
After-Hours Coverage			
Do you provide 24-hour coverage?		Describe Coverage	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA			
Do you have an answering service/machine?		Is your answering service/machine available at all times when you are not in the office?	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	
List below other after-hours arrangements or special instructions to patients for after-hours care needs:			

Misrepresentation of any statements and information provided by you in support of this application shall be considered fraudulent and may result in denial or revocation of appointment. (If more space is needed, please supply the information on a separate sheet and attach.)

Back-up Coverage (Please list the name, specialty, and telephone number of partner(s) or associate(s) or physician(s) covering your practice in your absence.)			
Name	Specialty	Partner, Associate, Or Covering	Telephone Number
			() -
			() -
			() -
			() -
Admitting Service			
Do you admit patients to the hospital under your own service?		If no, to whom do you admit?	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA			
Practitioner Extenders Please check any of the following licensed types of practitioners and list individual names who you either employ or utilize for direct patient care.			
<input type="checkbox"/> Physician's Assistant:		<input type="checkbox"/> Nurse Practitioner:	
<input type="checkbox"/> Nurse Midwife:		<input type="checkbox"/> Other (specify):	
Workers' Compensation Information			
Do you accept Workers' Compensation Patients?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please provide the following information:		a. Are staff trained in identification and care of patients with work-related illness/injury and provide care/services with an active return to work philosophy? <input type="checkbox"/> Yes <input type="checkbox"/> No b. Modified or alternative duty is actively evaluated for each Workers' Compensation claimant. <input type="checkbox"/> Yes <input type="checkbox"/> No c. Office will accommodate urgent walk-ins (or non-urgent appointments within 48 hours) to treat injured or ill workers and facilitate their return to work, if possible. <input type="checkbox"/> Yes <input type="checkbox"/> No d. Staff are available and willing to provide compensation representatives information regarding a claimant's care. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Clinical Guidelines			
Do you follow American College of Environmental Medicine (ACOEM) Guidelines? <input type="checkbox"/> Yes <input type="checkbox"/> No		If no, please explain other criteria utilized to treat patients.	

3. Medical/Professional Education:

Please provide the following information for your medical school of graduation.

Name of School	Degree Received	Dates of Attendance (List Mo/Yr)	
		From:	To:
Street Address	Phone # (if known)	Fax # (if known)	Graduation Date
	() -	() -	
City	State	Country	Zip Code

4. Professional Training - Internship/Residency/Fellowship/Post Graduate Professional Training /Other

List all, completed or not. (Attach copies of all program certificates.) All time gaps greater than three (3) months must be accounted for in Section 11. Not Applicable

Training Institution		Program	
		<input type="checkbox"/> Internship	<input type="checkbox"/> Fellowship
		<input type="checkbox"/> Residency	<input type="checkbox"/> Post Graduate Professional Training
		<input type="checkbox"/> Other:	
Street Address		City	
State	Country	Zip Code	
Telephone # (if known)		Fax # (if known)	
() -		() -	
Type of Training/Specialty	Dates of Training (Mo/Yr)	Was program successfully completed?	
	From: To:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
		If no, explain:	
Your Program Director's Name		Current Program Director's Name (if known)	

Training Institution		Program	
		<input type="checkbox"/> Internship	<input type="checkbox"/> Fellowship
		<input type="checkbox"/> Residency	<input type="checkbox"/> Post Graduate Professional Training
		<input type="checkbox"/> Other:	
Street Address		City	
State	Country	Zip Code	
Telephone # (if known)		Fax # (if known)	
() -		() -	
Type of Training/Specialty	Dates of Training (Mo/Yr)	Was program successfully completed?	
	From: To:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
		If no, explain:	
Your Program Director's Name		Current Program Director's Name (if known)	

Misrepresentation of any statements and information provided by you in support of this application shall be considered fraudulent and may result in denial or revocation of appointment. (If more space is needed, please supply the information on a separate sheet and attach.)

Training Institution		Program	
		<input type="checkbox"/> Internship <input type="checkbox"/> Residency	<input type="checkbox"/> Fellowship <input type="checkbox"/> Post Graduate Professional Training <input type="checkbox"/> Other:
Street Address		City	
State	Country	Zip Code	
Telephone # (if known)		Fax # (if known)	
() -		() -	
Type of Training/Specialty	Dates of Training (Mo/Yr)	Was program successfully completed?	
	From: To:	<input type="checkbox"/> Yes <input type="checkbox"/> No If no, explain:	
Your Program Director's Name		Current Program Director's Name (if known)	

Training Institution		Program	
		<input type="checkbox"/> Internship <input type="checkbox"/> Residency	<input type="checkbox"/> Fellowship <input type="checkbox"/> Post Graduate Professional Training <input type="checkbox"/> Other:
Street Address		City	
State	Country	Zip Code	
Telephone # (if known)		Fax # (if known)	
() -		() -	
Type of Training/Specialty	Dates of Training (Mo/Yr)	Was program successfully completed?	
	From: To:	<input type="checkbox"/> Yes <input type="checkbox"/> No If no, explain:	
Your Program Director's Name		Current Program Director's Name (if known)	

Misrepresentation of any statements and information provided by you in support of this application shall be considered fraudulent and may result in denial or revocation of appointment. (If more space is needed, please supply the information on a separate sheet and attach.)

5. State License(s): List all current professional licenses (Submit copy of current licenses)

State	License #	Issue Date	Expiration Date	Status (Please check)	Is/was license restricted?	Reason License is/was Inactive or Restricted
				<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Does the scope of your practice require the supervision of another practitioner?				<input type="checkbox"/> Yes <input type="checkbox"/> No		
If Yes, please list name of each supervising practitioner:				Practitioner Name:		

6. Certifications/Registrations

Federal DEA Certificate
 Not applicable
 (Submit copy of current DEA Certificates)

Certificate #	Expiration Date	Unlimited?
		<input type="checkbox"/> Yes <input type="checkbox"/> No If no, explain:
		<input type="checkbox"/> Yes <input type="checkbox"/> No If no, explain:
		<input type="checkbox"/> Yes <input type="checkbox"/> No If no, explain:

State CDS Certificate(s)
 Not applicable
 (Submit copy of current State Controlled Dangerous Substance Certificates, if applicable)

Certificate #	Expiration Date	Unlimited?
		<input type="checkbox"/> Yes <input type="checkbox"/> No If no, explain:

Other Certificate(s)/Formal Training
 (Please check below if currently certified. Submit copy(s))

- | | |
|---|---|
| <input type="checkbox"/> Basic Life Support (BLS) | <input type="checkbox"/> Anesthesia Permit |
| <input type="checkbox"/> Advanced Cardiac Life Support (ACLS) | <input type="checkbox"/> Health Care Practitioner (Core C) |
| <input type="checkbox"/> Pediatric Advanced Life Support (PALS) | <input type="checkbox"/> Neonatal Resuscitation Program (NRP) |
| <input type="checkbox"/> Advanced Trauma Life Support (ATLS) | <input type="checkbox"/> Therapeutics Classification Number (Optometrists only) |
| <input type="checkbox"/> Neonatal Advanced Life Support (NALS) | <input type="checkbox"/> Other (please list below or on a separate sheet and include descriptions): |

Misrepresentation of any statements and information provided by you in support of this application shall be considered fraudulent and may result in denial or revocation of appointment. (If more space is needed, please supply the information on a separate sheet and attach.)

7. Specialty Board Certification:

Submit copies of board certifications and/or qualification confirmation letter.

Are you board certified? Yes No (If yes, list below)

Certifying Board Name & Specialty	Initial Certification Date	Most Recent Recertification Date	Next Expiration Date

If not certified, are you qualified to sit for the examination? Yes No

If not certified, please indicate your status in the certifying process:

- Failed to pass specialty board examination
 - How many times have you taken the exam but failed to pass? _____
 - Last date(s) exam was taken: _____
- Date(s) board examination was taken/retaken and date board exam is scheduled, if applicable:
 - Date(s) taken/retaken: _____
 - Date scheduled, if applicable: _____
- Not eligible to take specialty boards
- Not planning to take specialty boards
- Admissible with exam pending

Misrepresentation of any statements and information provided by you in support of this application shall be considered fraudulent and may result in denial or revocation of appointment. (If more space is needed, please supply the information on a separate sheet and attach.)

(Photocopy this page for additional affiliations)

9. Hospital/Health Care Entity Affiliations:			
<input type="checkbox"/> Check here if entire section is not applicable to applicant.			
List ALL health care facilities at which you currently have privileges or have had privileges SINCE DATE OF LAST CREDENTIALING. Explain gaps greater than three (3) months during the period in Section 11.			
Name of Current Primary Hospital Affiliation		Type of Affiliation (e.g., Hospital, Nursing Home, etc.)	
Street Address		City	State Zip
Telephone Number		Fax Number	
() -		() -	
Department/Service		Department Chair's Name	
Staff Status (e.g., active, courtesy, provisional, employee)		# Admits/Month	Percent of time spent at facility
Restricted?		Dates of Affiliation (Mo/Yr)	
<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:		From:	To:
Reason for leaving, if applicable			
Name of Affiliation/Hospital/Healthcare Entity		Type of Affiliation (e.g., Hospital, Nursing Home, etc.)	
Street Address		City	State Zip
Telephone Number		Fax Number	
() -		() -	
Department/Service		Department Chair's Name	
Staff Status (e.g., active, courtesy, provisional, employee)		# Admits/Month	Percent of time spent at facility
Restricted?		Dates of Affiliation (Mo/Yr)	
<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:		From:	To:
Reason for leaving, if applicable			

Misrepresentation of any statements and information provided by you in support of this application shall be considered fraudulent and may result in denial or revocation of appointment. (If more space is needed, please supply the information on a separate sheet and attach.)

10. Work History/Experience:			
List in chronological order (beginning with current) all current and previous professional work history, including Military Service. You must explain gaps greater than three (3) months in Section 11. (If additional space is needed, please photocopy this page and attach.)			
Practice/Employer		Contact Name	
Street Address		City	State Zip
Telephone Number		Fax Number (if known)	
() -		() -	
Dates of Employment (Month/Year)		Job Title or Type of Work Performed	
From: To:			
Reason for leaving, if applicable			
Practice/Employer		Contact Name	
Street Address		City	State Zip
Telephone Number		Fax Number (if known)	
() -		() -	
Dates of Employment (Month/Year)		Job Title or Type of Work Performed	
From: To:			
Reason for leaving, if applicable			
Practice/Employer		Contact Name	
Street Address		City	State Zip
Telephone Number		Fax Number (if known)	
() -		() -	
Dates of Employment (Month/Year)		Job Title or Type of Work Performed	
From: To:			
Reason for leaving, if applicable			
Practice/Employer		Contact Name	
Street Address		City	State Zip
Telephone Number		Fax Number (if known)	
() -		() -	
Dates of Employment (Month/Year)		Job Title or Type of Work Performed	
From: To:			
Reason for leaving, if applicable			

11. Time Gaps

Provide information for all time frames of three (3) months or more that are not covered in Hospital/Facility Affiliations and/or Work History/Experience sections (such as extended travel, maternity leave, relocation, etc.).

Check here if entire section is not applicable to applicant.

Section	Dates	Explanation
Hospital/Health Care Entity Affiliations	From: To:	
	From: To:	
	From: To:	
Work History/Experience	From: To:	
	From: To:	
	From: To:	

12. Continuing Education Requirements

A. Have you completed the continuing education hours as required by your State Licensing Board during the past two (2) years OR the required CME/CEU hours (if applicable) from the State licensing board in which you are currently practicing? Yes No

B. Attach certificates as noted on Page 1 for the CME/CEU sessions you completed in last two (2) years (if required by Credentialing Entity).

13. Professional Associations/Organizations

List the associations/organizations related to your profession in which you are a member. Please include dates of affiliations. Include faculty appointments.

Check here if entire section is not applicable to applicant.

Professional Association/Organization	Dates of Affiliation
	From: To:
Professional Association/Organization	Dates of Affiliation
	From: To:
Professional Association/Organization	Dates of Affiliation
	From: To:
Professional Association/Organization	Dates of Affiliation
	From: To:
Professional Association/Organization	Dates of Affiliation
	From: To:

Misrepresentation of any statements and information provided by you in support of this application shall be considered fraudulent and may result in denial or revocation of appointment. (If more space is needed, please supply the information on a separate sheet and attach.)

14. Professional Liability Insurance Coverage:

Submit a copy of your current professional liability insurance coverage face sheet showing coverage in your practice specialty. Please list current and previous insurance carriers beginning with most current. (If additional space is needed, please photocopy this page and attach.)

Current Insurance Carrier		Telephone Number			
		() -			
Address		City	State	Zip	
Coverage Effective Date	Coverage Termination Date	Amount of Coverage		If Umbrella/Excess coverage, amount of coverage	
		\$ million/occurrence		\$	
		\$ million/aggregate			
Policy Number		Type of Coverage		Do you have prior acts coverage?	
		<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence		<input type="checkbox"/> No <input type="checkbox"/> Yes	
Previous Insurance Carrier		Telephone Number			
		() -			
Address		City	State	Zip	
Coverage Effective Date	Coverage Termination Date	Amount of Coverage		If Umbrella/Excess coverage, amount of coverage	
		\$ million/occurrence		\$	
		\$ million/aggregate			
Policy Number		Type of Coverage		Do you have prior acts coverage?	
		<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence		<input type="checkbox"/> No <input type="checkbox"/> Yes	
Previous Insurance Carrier		Telephone Number			
		() -			
Address		City	State	Zip	
Coverage Effective Date	Coverage Termination Date	Amount of Coverage		If Umbrella/Excess coverage, amount of coverage	
		\$ million/occurrence		\$	
		\$ million/aggregate			
Policy Number		Type of Coverage		Do you have prior acts coverage?	
		<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence		<input type="checkbox"/> No <input type="checkbox"/> Yes	
Previous Insurance Carrier		Telephone Number			
		() -			
Address		City	State	Zip	
Coverage Effective Date	Coverage Termination Date	Amount of Coverage		If Umbrella/Excess coverage, amount of coverage	
		\$ million/occurrence		\$	
		\$ million/aggregate			
Policy Number		Type of Coverage		Do you have prior acts coverage?	
		<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence		<input type="checkbox"/> No <input type="checkbox"/> Yes	

15. Professional Liability Insurance Coverage Disclosure: (Respond only for actions since date of last credentialing)

If the answer to any of these questions is yes, please provide a full explanation of the details of each and every matter on the attached Professional Liability Information Addendum. The explanation must include the name of the court in which the suit was filed, the caption and docket number of the case, and the name and address of the attorney defending you, and all other relevant details. Include suits in which a judgment or settlement was made against a professional corporation of which you are/were a member, shareholder, or employee in any matter in which you were involved in the patient's care.

<p>A. Has your professional liability insurance coverage ever been restricted, denied or terminated by action of the insurance company?</p>	<input type="checkbox"/> No	<input type="checkbox"/> Yes
<p>B. Has any (current or previous) professional liability insurance carrier excluded any specific procedures or specific area of practice (e.g., obstetrics, surgery, etc.) from your coverage?</p>	<input type="checkbox"/> No	<input type="checkbox"/> Yes
<p>C. During the time of your professional practice, have you had any professional liability claims, suits, settlements, or judgments filed against you or are any currently pending? If so, please complete, sign and date a Professional Liability Information Addendum page per each incident.</p>	<input type="checkbox"/> No	<input type="checkbox"/> Yes
<p>D. Have you ever practiced without professional liability coverage?</p>	<input type="checkbox"/> No	<input type="checkbox"/> Yes

Professional Liability Information Addendum

(Photocopy this form for each case/action)

Please supply the following:

- Information for each professional liability action you have had taken against you, with any actions or change of status, including those pending.
- Information for each settlement, or decision for the plaintiff that has occurred on your behalf.

All information is held in strict confidence and used for credentialing and recredentialing purposes only. Failure to supply sufficient details may prevent your application from being approved. In addition to completion of this form, practitioner may also submit any additional supporting documentation.

- Check here if entire section is not applicable to applicant.
 Check here if no professional liability actions/claims filed.

1. Case Number	2. Carrier Name
3. Court	4. Court address
5. Name of Plaintiff	6. Date of Incident
7. Date Filed	8. Date Closed
9. What was/is your status in the case?	10. What is the status of the case?
<input type="checkbox"/> Primary Defendant <input type="checkbox"/> Co-Defendant <input type="checkbox"/> Other, please explain:	<input type="checkbox"/> Dropped <input type="checkbox"/> Pending <input type="checkbox"/> Settled Out of Court <input type="checkbox"/> Found for Defendant <input type="checkbox"/> Dismissed Without Payment <input type="checkbox"/> Found for Plaintiff <input type="checkbox"/> Under Appeal
11. Amount of Any Settlement or Award?	12. Date of any Settlement or Award
12. Attorney's name	13. Attorney's address
Please explain the following in detail. (If an item does not apply please check "N/A")	
14. What was the alleged harm to the patient?	<input type="checkbox"/> N/A
15. What were you alleged to have done incorrectly or failed to do?	<input type="checkbox"/> N/A
16. Describe the patient's illness and related effects of the alleged harm.	<input type="checkbox"/> N/A
17. Describe any other details you believe are pertinent to the case.	<input type="checkbox"/> N/A
18. Identify any other parties named in the suit.	<input type="checkbox"/> N/A

16. Practice Disclosure Information:			
If the answer to any question below is yes, please provide a full explanation of the details on a separate sheet and attach.			
A. Have any investigations been initiated or are any pending against you by any state licensure board, registration board, or regulatory agency?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
B. Has your license to practice in any state ever been voluntarily or involuntarily relinquished, restricted, denied, reduced, limited, suspended, placed on probation, revoked, or subject to any disciplinary action including reprimand?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
C. Have you ever been suspended, sanctioned, or otherwise restricted from participating or been the subject of an investigation in any private, federal, or state health insurance program (e.g., Medicare, Medicaid)?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
D. Has your narcotics (DEA) registration certificate (federal or state) ever been voluntarily or involuntarily relinquished, limited, suspended, not renewed, placed on probation, revoked, or challenged?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> NA
E. Have you ever been convicted of or plead no contest to any criminal (felony or misdemeanor) charges including a drug or alcohol-related offense or motor vehicle offenses, but not including minor traffic or parking violations? Are any such proceedings currently pending?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
F. Have you ever had an academic appointment denied, limited, revoked, suspended, reduced, placed on probation, not renewed, or other adverse action taken?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> NA
G. Have you ever been refused membership on the medical or allied health staff of any hospital or institution or been denied advancement in staff status?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> NA
H. Has your employment, medical staff status, appointment, reappointment, or clinical privileges, or scope of practice ever been voluntarily or involuntarily suspended, restricted, reduced, revoked, denied, relinquished, not been renewed or subjected to probationary conditions or limited at any hospital, managed care organization or other health care entity?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
I. Have you ever been denied membership or renewal, or been reprimanded, censured, suspended, revoked, placed on probation, or otherwise sanctioned by any health care organization, including but not limited to, hospitals, HMOs, PPOs, IPAs, PHOs, professional associations or societies, professional standards review organization or peer review organizations, or any other health care facilities, based on professional competence?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
J. Have you ever withdrawn your application for appointment, reappointment or request for clinical privileges or resigned from the medical or allied health staff of a hospital, managed care organization, or other health care entity while under investigation or before a decision about your appointment or reappointment or clinical privileges was rendered by the governing board of any hospital, managed care organization or any other health care entity?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
K. Have you ever been allowed to resign your position or voluntarily relinquish specific clinical privileges rather than face any charge or investigation on the part of the medical staff of a hospital, managed care organization, or other health care entity?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
L. Are there currently pending adverse actions on your employment, medical staff appointment, reappointment, clinical privileges or scope of practice at any hospital, managed care organization, or other health care entity?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
M. Has any investigation (other than normal performance improvement reviews) involving your clinical practice, competence or professional conduct ever been initiated by any hospital, managed care organization, governmental agency, other health care entity, or branch of the armed forces?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	

Misrepresentation of any statements and information provided by you in support of this application shall be considered fraudulent and may result in denial or revocation of appointment. (If more space is needed, please supply the information on a separate sheet and attach.)

<p>N. Has your request for any specific clinical privileges or scope of practice ever been denied (as a result of disciplinary action) or granted with stated limitations or conditions (aside from ordinary initial probationary requirements of proctorship)? Are such proceedings currently pending?</p>	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
<p>O. Do you have any knowledge of any civil actions pending against you by any hospital, law enforcement agency, professional group or society?</p>	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
<p>P. Have you had any charges of unprofessional conduct brought against you?</p>	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
<p>Q. Have you had any charges of fraud brought against you?</p>	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
<p>R. Have you received any confirmed Quality Citations from a Peer Review Organization (PRO) in the last two (2) years? If you answered yes, on a separate sheet, indicate the address of the PRO that cited you, the circumstances of the citation and the number of points you were fined.</p>	<input type="checkbox"/> No	<input type="checkbox"/> Yes	

Health Status

<p>Note: Your application will be processed in the usual manner regardless of how you answer questions A and B. If you have answered "No" to question A or B, please explain completely on a separate sheet. If you are found to be qualified, a representative will contact you to determine what accommodations are necessary and feasible to allow you to practice safely.</p>
--

<p>A. Are you physically and mentally able to perform all the essential functions or services necessary to exercise the privileges or services applied for with or without a reasonable accommodation?</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p>B. Are you able to perform these functions without significant risk of injury to yourself or others?</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p>C. Do you illegally use drugs?</p> <p>Have you used illegal drugs within the last two years?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> No
<p>D. Do you currently take any medications that may affect your ability to perform the clinical privileges or scope of practice requested competently and safely?</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Misrepresentation of any statements and information provided by you in support of this application shall be considered fraudulent and may result in denial or revocation of appointment. (If more space is needed, please supply the information on a separate sheet and attach.)

ATTESTATION/AUTHORIZATION AND RELEASE OF INFORMATION

By submitting this attestation/authorization and release of information form in conjunction with the Provider Credentialing Application (PCA) and the Attestation/Authorization, I understand and agree as follows:

1. I understand and acknowledge that, as an applicant for medical staff membership and/or participating status with the Health Care Entity indicated on the PCA for initial credentialing or recredentialing, I have the burden of producing adequate information for proper evaluation of my competence, character, ethics, mental and physical health status, and/or other qualifications.
2. I further understand and acknowledge that the Health Care Entity or designated Agent will investigate the information in this application. By submitting this application, I agree to such investigation and to the disciplinary reporting and information exchange activities of the Health Care Entity as part of the verification and credentialing process.
3. I authorize all individuals, institutions, and entities or organizations with which I am currently or have been associated and all professional liability insurers with which I have had or currently have professional liability insurance, who may have information bearing on my professional qualifications, ethical standing, competence, and mental and physical health status to release the aforementioned information to the designated Health Care Entity(ies), their staffs and agents.
4. I consent to the inspection of records and documents that may be material to an evaluation of qualifications and my ability to carry out the requested clinical privileges or provide services I request. I authorize each and every individual and organization in custody of such records and documents to permit such inspection and copying. I am willing to make myself available for interviews if required or requested.
5. I attest to the accuracy and completeness of the information provided. I understand and agree that any misstatements in or omissions from the PCA Attestation/Authorization and attachments hereto may constitute cause for denial of the application or summary dismissal or termination of membership/clinical privileges/participation agreement.
6. I agree to exhaust all available procedures and remedies as outlined by in the bylaws, rules, regulations, and policies, and/or contractual agreements of the Health Care Entity(ies) where I have membership and/or clinical privileges/participation.
7. I understand that completion and submission of the PCA Attestation/Authorization and Release of Information does not automatically grant me membership or clinical privileges/participating status with the Health Care Entity(ies) indicated on the PCA or Attestation/Authorization.
8. I further acknowledge that I have read and understand the foregoing Attestation/Authorization and Release of Information. A photocopy of this Attestation/Authorization and Release of Information shall be as effective as the original, and authorization constitutes my written authorization and request to communicate any relevant information and to release any and all supportive documentation regarding this application/attestation/authorization.
9. I release from liability any and all individuals and organizations who provide information to the credentialing entity in good faith and without malice concerning my professional qualifications and competence, and the credentialing entity, from liability for their acts performed and statements made relating but not limited to verifying, evaluating and acting upon my credentials and qualifications.

Print Name Here: _____

Signature: _____

Date: _____

NOTE: Through above signature, I hereby affirm that contents are current, accurate, and complete as of the signature date.

Modification to the wording or format of the PCA/Attestation/Authorization and Release of Information may invalidate an application.

EZ Dental Care, Inc. will treat this application and any information secured in connection therewith in strict confidence in accordance with the Entities' policies and/or Medical Staff Bylaws and preserve with all reasonable safeguards the privacy of the Applicant.

ADDENDUM

VERIFICATION OF PROFESSIONAL LIABILITY

I, the undersigned, authorize my CURRENT professional liability insurance carrier,

(Enter Current Professional Liability Insurance Carrier Name)

(Enter Street Address)

(City)

(State & Zip)

to send verification of my professional liability coverage, to include dates of coverage, amounts of coverage, and any limitations in coverage, to EZ Dental Care, Inc.

EZ Dental Care, Inc. is to hereinafter be

a Certificate Holder and is to be notified of the amount of my coverage and any future changes in my insurance status, to include all information regarding claims history (but not necessarily limited to judgments entered, claims settled, cases and lawsuits pending) and any restriction regarding specific privileges which may be excluded from coverage.

I will notify EZ Dental Care, Inc. of any

changes in Professional Liability carriers so that another Verification of Professional Liability form can be completed.

Practitioner's Signature

Date

Printed Name

Policy Number

(Instructions: Please complete, sign, date and return to entity named above with your initial application.)